		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0002923

Facility Name: Heartland Manor Nursing Center

Address: 410 N.W. Third St. (Number) Casey (City) 62420 (Zip Code)

County: Clark

Telephone Number: (217) 932-4081 **Fax #** (217) 932-4922

IDPA ID Number: 370860567001

Date of Initial License for Current Owners: 12/18/64

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	X	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Michael W. Martin **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) David J. Sauer
(Title) Administrator

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title)
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	862	104	1,905	2,871	8
9	SNF/PED					9
10	ICF	14,406	9,703		24,109	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	15,268	9,807	1,905	26,980	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 74.66%

D. How many bed-hold days during this year were paid by Public Aid?
N/A (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 12/18/1964

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 28 and days of care provided 1,905

Medicare Intermediary Mutu al of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30/01 Fiscal Year: 6/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	198,553	14,060	6,068	218,681		218,681		218,681			1
2	Food Purchase		109,384		109,384		109,384	(10,701)	98,683			2
3	Housekeeping	84,118	16,624	737	101,479		101,479	(8,748)	92,731			3
4	Laundry	58,286	17,238	590	76,114		76,114		76,114			4
5	Heat and Other Utilities			89,364	89,364		89,364		89,364			5
6	Maintenance	36,473	4,410	40,466	81,349		81,349		81,349			6
7	Other (specify):*											7
8	**TOTAL General Services**	377,430	161,716	137,225	676,371		676,371	(19,449)	656,922			8
	B. Health Care and Programs											
9	Medical Director			4,500	4,500		4,500		4,500			9
10	Nursing and Medical Records	958,726	64,447	19,893	1,043,066		1,043,066		1,043,066			10
10a	Therapy		20,256	83,145	103,401		103,401		103,401			10a
11	Activities	53,761		5,109	58,870		58,870		58,870			11
12	Social Services	20,050		2,275	22,325		22,325		22,325			12
13	Nurse Aide Training			1,750	1,750		1,750		1,750			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,032,537	84,703	116,672	1,233,912		1,233,912		1,233,912			16
	C. General Administration											
17	Administrative	99,765			99,765		99,765		99,765			17
18	Directors Fees											18
19	Professional Services			88,716	88,716		88,716	(1,986)	86,730			19
20	Dues, Fees, Subscriptions & Promotions			8,914	8,914		8,914	(648)	8,266			20
21	Clerical & General Office Expenses	73,973	9,224	16,315	99,512		99,512		99,512			21
22	Employee Benefits & Payroll Taxes			288,319	288,319		288,319		288,319			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,290	6,290		6,290	(1,033)	5,257			24
25	Other Admin. Staff Transportation			1,729	1,729		1,729		1,729			25
26	Insurance-Prop.Liab.Malpractice			42,219	42,219		42,219		42,219			26
27	Other (specify):*											27
28	**TOTAL General Administration**	173,738	9,224	452,502	635,464		635,464	(3,667)	631,797			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,583,705	255,643	706,399	2,545,747		2,545,747	(23,116)	2,522,631			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heartland Manor Nursing Center #0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			90,459	90,459		90,459	(2,275)	88,184			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			19,409	19,409		19,409	(1,196)	18,213			32
33	Real Estate Taxes			2,160	2,160		2,160	(2,160)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			112,028	112,028		112,028	(5,631)	106,397			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	12,623	48,030	4,189	64,842		64,842		64,842			39
40	Barber and Beauty Shops			20	20		20		20			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):* Nonallowable costs			14,569	14,569		14,569	(14,569)				43
44	**TOTAL Special Cost Centers**	12,623	48,030	72,981	133,634		133,634	(14,569)	119,065			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,596,328	303,673	891,408	2,791,409		2,791,409	(43,316)	2,748,093			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,112)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,196)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,986)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(9,560)	43		24
25	Fund Raising, Advertising and Promotional	(3,342)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(309)	43		28
29	Other-Attach Schedule (See attached schedule)	(25,811)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (43,316)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (43,316)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Heartland Manor Nursing Center

ID# 0002923

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,986)	0	0	0	0	0	0	0	0	0	0	(1,986)	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,986)	0	0	0	0	0	0	0	0	0	0	(1,986)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,986)	0	0	0	0	0	0	0	0	0	0	(1,986)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,196)	0	0	0	0	0	0	0	0	0	0	(1,196)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,196)	0	0	0	0	0	0	0	0	0	0	(1,196)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(14,323)	0	0	0	0	0	0	0	0	0	0	(14,323)	43
44	**TOTAL Special Cost Centers**	(14,323)	0	0	0	0	0	0	0	0	0	0	(14,323)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(17,505)	0	0	0	0	0	0	0	0	0	0	(17,505)	45

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V		N/A						2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1									$		1
2											2
3											3
4											4
5	N/A										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6		N/A								6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Union Planters Bank		X	New wing	$4,545.00	12/1996	$ 510,000	$ 188,761	01/01/16	0.0775	$ 16,150	1
2												2
3	Lease obligations		X	Dishwasher	$59.00	6/1999	2,420	1,796	05/25/04	0.1612	339	3
4	Lease obligations		X	Electric beds	$1,277.00	3/2001	38,225	34,115	03/2004	0.1204	2,445	4
5	Lease obligations		X	Phone system	$243.00	9/1998	7,636		08/2001	0.0896	117	5
	Working Capital											
6												6
7	Various Vendor accounts		X	Finance charges							358	7
8												8
9	TOTAL Facility Related				$6,124.00		$ 558,281	$ 224,672			$ 19,409	9
	B. Non-Facility Related*											
10												10
11												11
12								Less: Non-allowable finance charges			(358)	12
13								Less: Interest income offset			(838)	13
14	TOTAL Non-Facility Related						$	$			$ (1,196)	14
15	TOTALS (line 9+line14)						$ 558,281	$ 224,672			$ 18,213	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2000	$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

N/A

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heartland Manor Nursing Center COUNTY Clark

FACILITY IDPH LICENSE NUMBER 0002923

CONTACT PERSON REGARDING THIS REPORT David J. Sauer, Administrator

TELEPHONE (217) 932-4081 FAX #: (217) 932-4922

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Facility pays real estate taxes		$	$
2.	on non-care asset. All costs		$	$
3.	are adjusted out of the cost report		$	$
4.			$	$
5.	03-11-19-08-203-046	Lots 8 & 9 Sturdevant & Gobel Addn	$ 733.00	$ Zero
6.	03-11-19-08-203-047	Lots 4 & 5 Sturdevant & Gobel Addn	$ 287.00	$ Zero
7.	03-11-19-08-203-049	Lots 2 Sturdevant & Gobel Addn	$ 1,228.00	$ Zero
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 2,248.00	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? See above YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 31,047 B. General Construction Type: Exterior Brick Frame Steel Number of Stories One

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	152,472	1964	$ 24,000	1
2					2
3	TOTALS	152,472		$ 24,000	3

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	78		1964	1964	$ 358,838	$	25	$	$	$ 358,838	4
5			1966	1966	21,735		25			21,735	5
6			1970	1970	3,400		25			3,400	6
7			1972	1972	11,798		25			11,798	7
8	21		1996	1996	828,949	20,724	40	20,724		103,621	8
	Improvement Type**										
9	Building improvements			1973	7,124		10			4,127	9
10	Building improvements			1974	28,947	910	14-30	910		26,201	10
11	Building improvements			1975	7,321		10-30			7,321	11
12	Building improvements			1976	1,520	28	10-30	28		1,382	12
13	Building improvements			1977	1,684		7			1,684	13
14	Building improvements			1978	16,114		5-15			16,114	14
15	Building improvements			1979	3,888		10			3,888	15
16	Building improvements			1980	3,223		7			3,223	16
17	Building improvements			1981	1,376		7			1,376	17
18	Building improvements			1982	13,986		3-30			13,986	18
19	Building improvements			1983	6,619		5			6,619	19
20	Building improvements			1984	18,714		5-15			18,714	20
21	Building improvements			1985	8,579	858	5-15	858		6,039	21
22	Building improvements			1986	45,792	4,580	10-20	4,580		35,144	22
23	Building improvements			1987	28,030	578	5-15	578		28,030	23
24	Building improvements			1988	5,444	363	12-15	363		4,899	24
25	Building improvements			1989	3,775	251	15	251		2,955	25
26	Building improvements			1990	1,151		7			1,151	26
27	Building improvements			1991	7,180		10			7,180	27
28	Heating/air system			1992	80,277	4,014	20	4,014		32,446	28
29	Building improvements			1992	3,084	308	10	308		2,929	29
30	Building improvements			1992	2,168	217	10	217		2,042	30
31	Wallpaper			1992	308	31	10	31		288	31
32	Building improvements			1992	647	65	10	65		583	32
33	Building improvements			1992	4,263	284	15	284		2,486	33
34	Ceiling/floor			1992	49,925	1,872	20	1,872		20,283	34
35	Sprinkler system			1992	60,121	2,255	20	2,255		25,301	35
36	Storage shelving			1993	4,090	307	10	307		3,340	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Storage shelving	1993	$ 1,003	$ 75	10	$ 75	$	$ 827	37
38	Resident security system	1993	3,909	147	20	147		1,596	38
39	Cabinets	1993	42,611	1,603	15-20	1,603		17,249	39
40	Heating/air/tubs	1993	29,226	1,096	20	1,096		11,012	40
41	Fire alarm system	1993	12,350	463	20	463		4,837	41
42	Plumbing and water system	1993	8,684	326	20	326		3,474	42
43	Cubicle tracking	1993	1,768	133	10	133		1,415	43
44	Building improvements	1994	9,921	372	20	372		3,477	44
45	Building improvements	1995	28,132	2,053	10-20	2,053		10,543	45
46									46
47	Architect fees	1996	74,806	1,872	40	1,872		9,832	47
48	Hvac/insulation/ducts	1996	30,292	759	40	759		3,291	48
49	Sprinklers	1996	9,774	183	40	183		1,159	49
50	Painting	1996	4,052	76	40	76		4,116	50
51	General contractor fees	1996	7,841	147	40	147		931	51
52	Electrical	1996	18,390	460	40	460		2,415	52
53	Chapel	1996	12,572	471	40	471		2,566	53
54	Curtain tracking	1996	742	28	20	28		183	54
55	Room signs	1996	3,331	125	20	125		792	55
56	Lighting	1996	142	5	20	5		37	56
57	Bathrooms	1996	8,610	323	20	323		2,050	57
58	Sprinklers	1996	340	26	10	26		162	58
59	Security locks	1996	1,049	39	20	39		245	59
60	Carpeting	1996	3,436	129	20	129		816	60
61	Call lights	1996	1,881	71	11	71		524	61
62	Air filtration	1996	2,081	78	20	78		494	62
63	Wiring	1996	2,970	446	5	446		2,822	63
64	Hallway support bars	1996	750	56	10	56		350	64
65	Capitalized interest-new wing	1996	4,700	88	40	88		559	65
66	Plumbing	1996	4,640	174	20	174		1,211	66
67	Electrical work	1996	4,662	175	20	175		1,132	67
68	Flooring	1996	2,400	90	20	90		568	68
69	Courtyard	1996	2,766	104	20	104		645	69
70	TOTAL (lines 4 thru 69)		$ 1,979,901	$ 49,838		$ 49,838	$	$ 870,453	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,979,901	$ 49,838		$ 49,838	$	$ 870,453	1
2	Concrete work entrance	1996	1,470	55	20	55		337	2
3	Building appraisal	1997	2,578	48	40	48		344	3
4	Chapel HVAC	1997	2,324	87	20	87		497	4
5	Stained glass window	1997	2,052	76	20	76		410	5
6	Steel door	1997	422	16	20	16		83	6
7	Hot water heater - North Wing	1997	3,838	144	20	144		768	7
8	Hot water heater - Laundry	1997	2,893	108	20	108		554	8
9	Hand rails	1997	5,252	197	20	197		985	9
10	Painting	1997	478	18	20	18		88	10
11	Walk in cooler	1997	11,524	432	20	432		2,112	11
12	Fire system work	1997	513	19	20	19		90	12
13	Key pad - security system	1997	360	14	20	14		65	13
14	Hot water heater - Kitchen	1997	3,508	132	20	132		614	14
15	Tile flooring - Lobby	1997	900	34	20	34		158	15
16	Hot water heater	1998	7,318	366	20	366		1,280	16
17	Bed light installation	1998	1,826	91	20	91		304	17
18	Hand rails	1998	1,413	71	20	71		230	18
19	Sprinklers	1998	708	35	20	35		114	19
20	Generator bypass switch	1998	1,567	78	20	78		247	20
21	Carpeting in lobby	1998	727	36	20	36		87	21
22	Lighting - kitchen	1998	985	49	20	49		151	22
23	Paging system	1998	516	26	20	26		76	23
24	Room divider remodeling	1998	391	20	20	20		58	24
25	Bathroom lighting	1998	1,090	55	20	55		155	25
26	South wing remodeling	1998	165	8	20	8		22	26
27	Roof over generator room	1998	568	28	20	28		80	27
28	Bathrooms	1998	7,394	370	20	370		1,017	28
29	Bathrooms-South & Hutton	1998	6,197	310	20	310		801	29
30	Fire Alarm System	1999	1,317	66	20	66		891	30
31	Fire & Smoke Dampers	1999	1,664	83	20	83		173	31
32	Generator Work for Heating	1999	1,760	88	20	88		190	32
33	Generator panel	1999	2,023	202	10	202		320	33
34	TOTAL (lines 1 thru 33)		$ 2,055,642	$ 53,200		$ 53,200	$	$ 883,754	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,055,642	$ 53,200		$ 53,200	$	$ 883,754	1
2									2
3	Gazebo	2000	2,733	167	10	167		167	3
4	Anti-scald valves (2)	2001	655	33	10	33		33	4
5	Shower floor replacement	2001	500	13	20	13		13	5
6	Dining room lights	2001	6,013	150	20	150		150	6
7									7
8									8
9	Reconciling items		(6,792)	2,081		2,081		(10,080)	9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,058,751	$ 55,644		$ 55,644	$	$ 874,037	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 385,783	$ 29,413	$ 29,413	$	5-15	$ 265,637	71
72	Current Year Purchases	58,393	3,127	3,127		10	3,127	72
73	Fully Depreciated Assets	89,609					89,609	73
74								74
75	TOTALS	$ 533,785	$ 32,540	$ 32,540	$		$ 358,373	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Care	1994 Ford Van	1994	$ 41,610	$	$	$	5	$ 41,610	76
77										77
78										78
79										79
80	TOTALS			$ 41,610	$	$	$		$ 41,610	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,658,146	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 88,184	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 88,184	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,274,020	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Aklinski building - 1994	$ 40,045	$ 1,027	$ 6,931	86
87	Aklinski parking lot-1996	3,900	195	910	87
88	Delaware house-1998	17,550	451	1,463	88
89	Land-1994, 1998, 2000	30,000	n/a	n/a	89
90	Repp House - 2000	38,500	602	602	90
91	TOTALS	$ 129,995	$ 2,275	$ 9,906	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ n/a NO

16. Rental Amount for movable equipment: $ N/A Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		1,750		1,750
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 1,750	$	$ 1,750
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,750			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Ln 10A(2),(3)	hrs	$	1,762	$ 26,429	$ 4,704	1,762	$ 31,133	1
2	Licensed Speech and Language Development Therapist	Ln 10A(3)	hrs		357	5,349		357	5,349	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Ln 10A(3)	hrs		3,424	51,367		3,424	51,367	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Ln 39(2)	# of prescrpts				46,805		46,805	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	Ln 39(1),(2)		12,623			1,225		13,848	12
13	Respiratory therapy Other (specify): (See attached)	Ln 10A(2) Ln 39(3)				4,189	15,552		15,552 4,189	13
14	TOTAL			$ 12,623	5,543	$ 87,334	$ 68,286	5,543	$ 168,243	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 101,710	$ 101,710	1
2	Cash-Patient Deposits	5,328	5,328	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 6,000)	427,991	427,991	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,562	33,562	6
7	Other Prepaid Expenses	33,332	33,332	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intererst earned rec.	54	54	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 601,977	$ 601,977	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	351	351	12
13	Land	54,000	24,000	13
14	Buildings, at Historical Cost	1,672,285	1,572,290	14
15	Leasehold Improvements, at Historical Cost	482,952	482,952	15
16	Equipment, at Historical Cost	575,395	575,395	16
17	Accumulated Depreciation (book methods)	(1,283,926)	(1,274,020)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Security deposit	59	59	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,501,116	$ 1,381,027	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,103,093	$ 1,983,004	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 105,821	$ 105,821	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,328	5,328	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	109,398	109,398	30
31	Accrued Taxes Payable (excluding real estate taxes)	4,331	4,331	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	762	762	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee annuity	2,834	2,834	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 228,474	$ 228,474	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	35,911	35,911	39
40	Mortgage Payable	188,761	188,761	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Lease obligations & contracts			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 224,672	$ 224,672	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 453,146	$ 453,146	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,649,947	$ 1,529,858	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,103,093	$ 1,983,004	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,500,589	1
2	Restatements (describe):		2
3			3
4	**Auditor's adjustments subsequent to preparation**		4
5	**of 2000 cost report**	53,937	5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,554,526	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	95,421	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 95,421	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,649,947	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,723,340	1
2	Discounts and Allowances for all Levels	(171,290)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,552,050	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	115,273	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 115,273	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,701	14
15	Telephone, Television and Radio	2,027	15
16	Rental of Facility Space	6,715	16
17	Sale of Drugs	33,224	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	1,844	19
20	Radiology and X-Ray		20
21	Other Medical Services	91,617	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 146,128	23
	D. Non-Operating Revenue		
24	Contributions	2,106	24
25	Interest and Other Investment Income***	838	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 2,944	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See attached	62,670	28
28a	Medicare settlement	7,765	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 70,435	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,886,830	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	676,371	31
32	Health Care	1,233,912	32
33	General Administration	635,464	33
	B. Capital Expense		
34	Ownership	112,028	34
	C. Ancillary Expense		
35	Special Cost Centers	79,431	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,791,409	40
41	**Income before Income Taxes (line 30 minus line 40)****	95,421	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 95,421	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 39,380	$ 18.93	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,579	13,680	226,110	16.53	3
4	Licensed Practical Nurses	13,811	14,947	190,531	12.75	4
5	Nurse Aides & Orderlies	51,133	55,433	485,083	8.75	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,000	2,080	14,916	7.17	9
10	Activity Assistants	4,828	4,982	38,845	7.80	10
11	Social Service Workers	2,007	2,195	20,050	9.13	11
12	Dietician					12
13	Food Service Supervisor	2,000	2,080	21,901	10.53	13
14	Head Cook					14
15	Cook Helpers/Assistants	20,060	21,524	176,652	8.21	15
16	Dishwashers					16
17	Maintenance Workers	3,229	3,349	36,473	10.89	17
18	Housekeepers	11,995	12,503	84,118	6.73	18
19	Laundry	7,407	7,835	58,286	7.44	19
20	Administrator	1,920	2,080	99,765	47.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,877	6,247	73,973	11.84	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health C: (See attached)	1,973	2,535	30,245	11.93	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	142,779	153,550	$ 1,596,328 *	$ 10.40	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	118	$ 5,040	1(3)	35
36	Medical Director	12	4,500	9(3)	36
37	Medical Records Consultant	24	1,620	10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	1,020	10(3)	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,275	11(3)	44
45	Social Service Consultant	48	2,275	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	262	$ 16,730		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	267	4,847	10(3)	52
53	TOTAL (lines 50 - 52)	267	$ 4,847		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
David J. Sauer	Administrator	0%	99,765
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 99,765

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Larsson, Woodyard & Henson	Audit	$ 13,300
Duane, Morris & Heckscher	Legal	47,087
Dennis Simonton	Legal	1,986
Altschuler, Melvoin & Glasser	Accounting	8,105
Systematic Management Sys.	Operations consulting	5,072
Quorem Consulting	Retirement plan admin	3,660
American Expr. Tax & Bus. Scvs.	Accounting	3,149
Midwest Nursing Professionals	Operations consulting	3,257
Personnel Planners	Unemployment consultant	810
Charley, Inc.	Computer consultation	867
Mgmt. Prof. For Healthcare	Operations consulting	1,423
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 88,716

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 31,810
Unemployment Compensation Insurance	6,246
FICA Taxes	120,469
Employee Health Insurance	77,881
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	1,406
Employee Life & Additional Health Coverage	32,239
Employee Labs & Physicals	268
Profit Sharing Plan, Retirement	18,000
TOTAL (agree to Schedule V, line 22, col.8)	$ 288,319

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
NA		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 34)	408
Various licenses	77
IL Health Care Association dues	4,056
AHCA Facilitator fees	935
NAEIR	475
Sam's Club	525
Various dues & subscriptions	2,438
Less: Public Relations Expense	(648)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,266

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	
See attached schedule	6,290
Less: Out of state travel	(1,033)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,257

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heartland Manor Nursing Center # 0002923 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6					N/A								
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Heartland Manor Nursing Center **#** 0002923 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - 4,056**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,179** Line **10 (2)**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **10,701**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Larsson, Woodyard & Henson** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will provide copy when completed**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Heartland Manor Nursing Center
Provider # 00002923
07/01/00 - 06/30/01

Supplementary Information

Page 5 - Non-allowable expenses: Line 29	Amount	Reference
Offset food income against cost	(10,701)	2
Other non-allowable advertising	(246)	43
Non-allowable travel & seminar	(1,033)	24
Non-allowable dues & subscriptions	(648)	20
Offset cleaning cost against rent income	(8,748)	3
Non-care related depreciation	(2,275)	30
Non-care related real estate taxes	(2,160)	33
	(25,811)	

Page 16 - Special services: Line 13	Column #	Amount	Reference
Oxygen	5	2,690	39(3)
Laboratory	5	1,355	39(3)
X Ray	5	144	39(3)
		4,189	

Page 20 - Staffing & salary: Line 32	Hrs worked	Hrs paid	Amount	Hrly wage
Care plan coordinator	1,973	2,535	30,245	11.93

Page 6 - Non-Profit required attachment - List of Board of Directors:

Board Member	Directly Provided Services	Type of Service	Entity owned doing business with facility	Type of Business conducted
David Hensiek - President	no			
Betty Styer	no			
Tom Marsh	no			
Mark Ahrens	yes	Grocery	Casey IGA	Food
Jim Niksch	no			
Marilyn Resch - Secretary	no			
Ted Perillo - Vice President	yes	Pharmacy consultant	Pharmacy Shop	Pharmacy

Page 19 - Other revenue: Line 28	
Vending income	731
Oil income	116
IDPA Oxygen billings	34,881
Bed rental income	2,170
Employee portion of tax on 401(k)	1,599
Tube feeding income	516
Shirts & jackets	3,738
Cleaning income	18,000
Misc. receipts & employee reimbursement	919
	62,670

Page 21 - Professional services	
Total per schedule	88,716
Non-allowable collection costs	(1,986)
Total per Schedule V, line 19, column 8	86,730

RECONCILIATION REPORT **Heartland Manor Nursin** **02:56 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-43,316	equal to	-43,316	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	18,213	equal to	18,213	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	88,184	equal to	88,184	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	0	equal to	0	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	1,750	equal to	1,750	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	12,623	equal to	12,623	0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	87,849	equal to	103,401	-15,552	FAILED	Pg16 Z12+Z14..	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	68,286	equal to	68,286	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	676,371	equal to	676,371	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,233,912	equal to	1,233,912	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	635,464	equal to	635,464	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	112,028	equal to	112,028	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	79,431	equal to	79,431	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	54,203	equal to	54,203	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	941,104	equal to	958,726	-17,622	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	12,623	-12,623	FAILED	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	53,761	equal to	53,761	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	20,050	equal to	20,050	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	198,553	equal to	198,553	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	36,473	equal to	36,473	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	84,118	equal to	84,118	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	58,286	equal to	58,286	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	99,765	equal to	99,765	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	73,973	equal to	73,973	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,596,328	equal to	1,596,328	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,040	< or = to	6,068	-1,028	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,500	< or = to	4,500	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	7,487	< or = to	19,893	-12,406	O.K.	Pg20 X14..X16+	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	2,275	< or = to	5,109	-2,834	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	2,275	< or = to	2,275	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	99,765	equal to	99,765	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	88,716	equal to	88,716	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	288,319	equal to	288,319	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	8,266	equal to	8,266	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	5,257	equal to	5,257	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	54,203	equal to	54,203	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,905	equal to	1,905	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6l Y4(	B.	14	8
Total loan balance	224,672	equal to	224,672	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	24,000	equal to	24,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	2,058,751	equal to	2,055,242	3,509	FAILED	Pg12 to 12l L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	575,395	equal to	575,395	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,274,020	equal to	1,274,020	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,649,947	equal to	1,649,947	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	95,421	equal to	95,421	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	2,103,093	equal to	2,103,093	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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